PRENATAL CARE COORDINATION COMBINED INITIAL AND RE-ASSESSMENT FORM

AGENCY:_____ ADDRESS:_____

CONTACT PERSON:_____ PHONE:_____

CARE COORDINATOR'S PROVIDER # FAX BACK # OF PNCC**:**

MCO:_____ DATE:_____

CONTACT PERSON: _____

PHONE:_____ FAX:_____

MEDICAID #: _ _ _ _ _ _ _ _ _ _ _ _	***SS#:***	LMP**:**	EDC**:**
NAME:		***DOB*** (mm/dd/yy):	
RACE:	***HISPANIC:*** _Y _N	***EDUCATION:***	***MARITAL STATUS:***
Phone 1:	Phone 2:	***COUNTY*** of Residence:	
Address 1:	Address 2:		
Prenatal Care Provider:	Location:	Phone:	
PMP	Phone:	Fax:	

INITIAL HV H1000	**F / U**	**1ST REASSESS H1004**	**1ST REASSESS F/U**	**2ND REASSESS H1004**	**2ND REASSESS F/U**
Auth#		Auth#:		Auth#:	
Date:	Date	Date:	Date:	Date:	Date:
Miles	Miles	Miles:	Miles:	Mile:	Mile:
Wks Gestation	Wks Gestation	Wks Gestation	Wks Gestation	Wks Gestation	Wks Gestation
PNCC:	PNCC: CHW	PNCC: CHW:	PNCC: CHW:	PNCC: CHW:	PNCC: CHW:

RISK FACTORS	***INITIAL ASSESSMENT:***	***REASSESSMENT 1:***	***REASSESSMENT 2:***

ASSESSMENT	COMMENTS/TEACHING/HANDOUTS	CODES: X = Significant O = No Problem P = Potential N – See Note					
1. PREVIOUS PREGNANCY HX		*Initial HV*	*F/U*	*1st Reassess*	*Reassess F/U*	*2ND Reassess*	*Reassess F/U*
A. Parity / Gravida							
B. Substance Use (tobacco, alcohol, drugs)							
C. STD/HIV							
D. Past pregnancy complications							
E. Weight problems							
F. Previous depression / PP depression							
G. Maternal Medical History							
2. CURRENT PREGNANCY							
A. Intendedness	(Did she want to be pregnant sooner, now, later or never)						
B. First prenatal care appointment	(Date and ***MONTH OF GESTATION***)						
C. In prenatal care prior to initial PNCC enrollment?	☐ Y ☐ N						
D. Number of PNC visits	(Total per trimester)						
E. Next prenatal visit (date)							
F. Missed appointments	***(Who rescheduled missed appt?)***						
G. Barriers to care							
Reason missed appts. NA=00 Transportation=01 Childcare=02 Weather=03 Forgot=04 Illness=05 Appt. Hours Inconvenient=06 Job/School=07 Unknown=99 Other=							
H. Current Pregnancy Complications							
1. Significant bleeding							
2. Preterm labor symptoms							
3. Infections (BV, UTI, STD, dental,)							
4. Swelling, headache, blurred vision							
5. Illness since last visit/ER visit							
6. Fetal movement							
I. STD/HIV							
J. Douching							

Information required for Medicaid Prenatal Outcome Report is bolded and italicized

PRENATAL CARE COORDINATION COMBINED INITIAL AND RE-ASSESSMENT FORM

ASSESSMENT	COMMENTS/TEACHING/HANDOUTS	Initial HV	F/U	1st Reassess	Reassess F/U	2nd Reassess	Reassess F/U
K. ***SUBSTANCE USE***							
1. TOBACCO (AMT)							
2. ALCOHOL/ DRUGS							
3. ILLICIT DRUGS							
4. Prescription/OTC drugs							
L. WEIGHT THIS VISIT	(wt in pounds_____) (Prepregnancy wt _____)						
M. Weight gain/loss							
N. Cultural practices in pregnancy							
O. Allergies							
P. Mental health (illness)							
3. NUTRITION STATUS							
A. Appetite							
B. Diet (24 hour recall)							
Breakfast ☐Y ☐N What							
Lunch: ☐Y ☐N What							
Supper: ☐Y ☐N What							
Snacks ☐Y ☐N What							
C. Glasses of water							
D. Adequate Food Supply							
E. Prenatal vitamins / folic acid / iron							
F. Mineral/Herb Supplements							
G. On WIC (picking up vouchers?)							
H. On WIC prior to PNCC contact?	☐***Y*** ☐***N***						
I. PICA							
4. HOME ENVIRONMENT							
A. Language Spoken in home							
B. Housing: Adequacy/Safety							
# in household / adequate space							
Cleanliness (roaches, vermin)							
Utilities / stove / refrigerator							
C. Safety: smoke detectors / guns							
D. Neighborhood environment / safety							
E. Plans to move? Where							
F. Moves frequently >3 times in 12 mo.							
5. PSYCHOSOCIAL							
A. Perceived Support Level	Does she feel her support is adequate/inadequate						
B. Support Person (who?)							
C. Relationship with father of baby							
D. Domestic Violence							
E. Employment							
F. Inadeq. Income to meet basic need							
G. Job Hazards							
H. Perceived health status	Would you say your general health is excellent, very good, good, fair, or poor						
I. Perceived mental health status	Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?						
J. Perceived Stress Level	1-none, 2-some, 3-moderate, 4-high, 5-very high						

NOTE: All information required for Medicaid Prenatal Outcome Report is bolded and italicized .

PRENATAL CARE COORDINATION COMBINED INITIAL AND RE-ASSESSMENT FORM

ADDITIONAL NOTES

Initial Assessment Home Visit:

Initial Assessment F/U:

Reassessment 2nd Trimester

Reassessment 2nd Trimester F/U

Reassessment 3RD Trimester

Reassessment 3rd Trimester F/U

REFERRALS

Date	Referral	Date	Referral	Date	Referral	Date	Referral
	Adoption		Family Support/ parenting		Nutritionist / EFNEP		Smoking Cessation
	Alcohol / Drug Abuse Services		Family Planning		Pediatrician		Township trustee
	Adult Education / GED		Food/Clothing/Baby items		Post Partum Care		Transportation
	Child Birth Education		Healthy Families		Prenatal Care		WIC
	DFC / Food Stamps/ TANF		Human Services		Rent / Utility Assistance		
	Domestic Violence Program		Medicaid		Shelter, Homeless/ violence		
	Employment		Mental Health		Social Services		

EDUCATION TOPICS

Date	Education Topic	Date	Education Topic	Date	Education Topic	Date	Education Topic
	Breastfeeding		Family Planning		Personal care		Shaken Baby Syndrome
	Community Resources		HIV risks/testing		Prenatal Care early/adequate		Smoking cessation
	Contraceptive methods		Kick Counts		Preterm Labor		STD signs of infection
	Coping Skills		Labor and delivery		Post Partum Depression		Vitamins/ Folic acid / Iron
	Dental health		Lessons learned		Post partum/NB care		Warning signs of pregnancy
	Domestic volence prevent		Normal discomforts		Safe sleep		When to call the doctor
	Drug/alcohol cessation		Nutrition		Seat belt/car seat		
	Immunization/well baby		Prenatal weight gain		Secondhand Smoke		

PRENATAL CARE COORDINATION COMBINED INITIAL AND RE-ASSESSMENT FORM

PARTICIPANT TERMINATION FROM PROGRAM

Client terminated prior to Post Partum assessment? ☐Y ☐N	**Reason terminated: ☐Refused Service ☐Moved ☐Lost to F/U ☐Other**

If client terminated prior to post partum assessment complete the following. Send in the outcome report to the Managed Care Organization at the time of the termination or with the last billing.

Total Care Coordination Services		
Total Services Provided	Initial assessment + 2 reassessments + outcome = 01	Initial assessment + 1 reassessment + outcome =02
	Initial assessment + 2 reassessments = 03	Initial assessment + 1 reassessment = 04
	Initial assessment + outcome = 05	Initial assessment only = 06

Total Number of Encounters By:	**Prenatal Care Coordinator**				**Community Health Worker**			

PNCC/CHW Signatures:

Name	Title	Data of Encounter

NOTE: All information required for Medicaid Prenatal Outcome Report is highlighted in gray.